Tennessee Department of Children's Services

PSYCHOTROPIC MEDICATION EVALUATION

Child's Name_____ DOB_____ Date_____

Social Security #_____ Home County _____

DCS Case Mgr _____

DSM Diagnosis:

Axis I_____

Axis II_____

Axis III_____

Axis IV _____

Axis V _____

Target symptoms?_____

What other treatments are provided? (e.g. individual/ family therapy)

_____

Medications: (name, dose, frequency, route)

#1_____ Refills_____

Is this an increase_____, decrease_____, or no change_____ from the previous prescription?

#2_____ Refills_____

Is this an increase_____, decrease_____, or no change_____ from the previous prescription?

#3_____ Refills_____

Is this an increase_____, decrease_____, or no change_____ from the previous prescription?

#4_____ Refills_____

Is this an increase_____, decrease_____, or no change_____ from the previous prescription?

Is any medication being discontinued?_____

Discontinued due to lack of efficacy? _____, Or side effects? _____

What were side effects/adverse effects experienced? _____

_____

Comments/additional information_____

_____

Are there any follow-up laboratory tests?_____Next appointment_____

Agency name_____

Prescribing provider's name_____

Signature_____